101 Parklane Boulevard – Suite 301, Sugar Land, TX 77478
Customer Service 877.493.6282 Fax 832.415.0379

Dental Source of Missouri & Kansas

Plan Options for the City of St. Louis

FCL Dental/Dental Source, is once again please to offer the following DHMO/Managed Care Dental Plans to employees of the City of St. Louis for the 2017-2018 Year.

FREE ACCESS PLAN

- No charge for routine exams, x-rays, and cleanings
- Extensive provider network
- No need to pre-select a dental office
- Family members can utilize different dentists
- Plan co-pay's do not increase if the services of a specialist are required
- No deductibles to pay and no yearly maximums on coverage
- No waiting periods
- Orthodontic discounts for both adults and children
- No pre-existing condition exclusions

Free Access Plan Bi-Weekly Payroll Deductions

Employee Only	$6.14
Employee + One	$10.18
Employee + Family	$15.81

Plan E

- No charge for routine exams, x-rays, and cleanings
- Extensive provider network
- Eligibility requires the pre-selection of a network dentist
- Co-pays of 30% to 50% of the dentists usual fees on Basic and Major procedures
- Specialty Care provided at a reduced fee
- No deductibles to pay and no yearly maximums on coverage
- No waiting periods
- Orthodontic discounts for both adults and children
- No pre-existing condition exclusions

Plan E Bi-Weekly Payroll Deductions

Employee Only	$3.80
Employee + One	$6.42
Employee + Family	$9.50

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Enrollment Form: City of St. Louis

Part 1	EFFECTIVE DATE:			
	2. SOCIAL SECURITY NUMBER	3. NAME (LAST)	(FIRST)	
	4. ADDRESS			
	(CITY)	(STATE)	(ZIP CODE)	
	5. WORK PHONE	6. HOME PHONE	7. DATE OF BIRTH	8. SEX O Female O Male

9. DEPENDANT INFORMATION - LIST ALL ELIGIBLE DEPENDANTS YOU WISH TO BE COVERED

	NAME (LAST) (FIRST)	DATE OF BIRTH	SEX	RELATION TO APPLICANT
Part 2				

Part 3	Select Plan and Coverage Type→		Free Access Plan ☐	Plan E ☐ (see part 4)
			Bi-Weekly Rate	Bi-Weekly Rate
	O Employee Only		$6.14	$3.80
	O Employee + One		$10.18	$6.42
	O Employee + Family		$15.81	$9.50

Part 4	If you have selected Plan E, you must select a network provider: *(Please choose only one General Dentist for entire family)*	
	Provider Name:	Provider Number:
Part 5	I have read and understand the terms and conditions of the program and hereby request membership with Dental Source of Missouri & Kansas, Inc. I further authorize my employer to deduct from my salary the bi-weekly premium for the Dental Source coverage that I have selected.	
	SIGNATURE	DATE

Dental Source

Dental Health Care Plans

Schedule of Benefits – Plan E

City of St. Louis

The American Dental Association (ADA) assigns code numbers to each dental service. The Schedule of Services below provides you with an easy reference to the coverage associated with the Dental Source Program. All co payments are paid directly to your selected participating general dentist and are due at the time of service. All dental services listed in this schedule are provided **exclusively** by Dental Source network general dentists. There is no coverage outside of the Dental Source network. If the services of a Specialist are required, the member will receive a 20% discount off the usual fees from a participating Specialist, where available.

ADA CODE	PROCEDURE	Copayment
Diagnostic and Preventive – General Dentists Office		
****	Consultation	No Charge
0120	Periodic Oral Examination	No Charge
0140	Limited Oral Evaluation-Problem Focused	No Charge
0150	Comprehensive Oral Evaluation	No Charge
0160	Detailed & Extensive Oral Evaluation	No Charge
0210	Full Mouth X-Ray (Once Every 5 Years)	No Charge
0220	Initial Periapical X-Ray	No Charge
0230	Additional Periapical X-Ray	No Charge
0240	Occlusal X-Ray	No Charge
0250-60	Extraoral X-Ray	No Charge
0270-77	Bitewing X-Ray	No Charge
0330	Panoramic X-Ray (Once Every 5 Years)	No Charge
0460	Tooth Pulp Vitality Test	No Charge
0470	Diagnostic Casts - Study Models	No Charge
1110	Prophylaxis-Adult-Every 6 Months*	No Charge
1120	Prophylaxis-Child-Every 6 Months*	No Charge
1203	Topical Application of Fluoride-Child-Every 6 Months	No Charge
1330	Oral Hygiene Instruction	No Charge
1351	Sealant	50%
1510	Space Maintainer-Fixed-Unilateral	50%
1515	Space Maintainer-Fixed-Bilateral	50%
1520	Space Maintainer-Removable-Unilateral	50%
1525	Space Maintainer-Removable-Bilateral	50%
****	Difficult prophylaxis may be subject to a $20.00 charge.	
Restorative (Fillings, Inlays and Onlays) - General Dentist Office		
2140	Amalgam- One Surface Primary or Permanent	30%
2150	Amalgam- Two Surfaces Primary or Permanent	30%
2160	Amalgam- Three Surfaces Primary or Permanent	30%
2161	Amalgam- Four or More Surfaces Primary or Permanent	30%
2210	Silicate Cement-Per Restoration	50%
2330-35	Resin-Based Composite- 1, 2, 3 or 4 Surfaces, Anterior	30%
2390	Resin-Based Composite Crown, Anterior	50%
2391-94	Resin-Based Composite 1 or More Surface-Posterior-**Primary**	30%
2391-94	Resin-Based Composite-Posterior **Permanent**	70%
2410-30	Gold Foil-1, 2 or 3 Surfaces	50%
2510-30	Inlay-Metallic-1, 2, 3 or More Surfaces	50%
2542-44	Onlay-Metallic-2,3 or 4 Surfaces	50%
2610-30	Inlay-Porcelain/Ceramic1, 2,3 or More Surfaces	50%
2642-44	Onlay-Porcelain/Ceramic 1, 2, 3 or More Surfaces	50%
2650-52	Inlay- Resin-Based Composite -1, 2, 3 or More Surfaces	50%
2662	Onlay-Resin-Based Composite-2, 3, 4 or More Surfaces	50%
2664	Onlay-Composite/Resin-4 or more Surface/Lab Process	50%
2940	Sedative Fillings	30%
****	Laboratory Fees are Not Covered by the Dental Source Plan	
Restorative (Crowns-Single Restorations) - General Dentist Office		
****	Crown-Temporary in Conjunction With Permanent	No Charge
2710	Crown-Resin (Indirect)	50%
2720	Crown-Resin with High Noble Metal	50%
2721	Crown-Resin with Predominantly Base Metal	50%
2722	Crown-Resin with Noble Metal	50%
2740	Crown-Porcelain/Ceramic Substrate	50%
2750	Crown-Porcelain Fused to High Noble Metal	50%
2751	Crown-Porcelain Fused to Predominantly Base Metal	50%
2752	Crown-Porcelain Fused to Noble Metal	50%
2780-83	Crown-3/4	50%
2790	Crown-Full Cast High Noble Metal	50%
2791	Crown-Full Cast Predominantly Base Metal	50%
2792	Crown-Full Cast Noble Metal	50%
2910	Recement Inlay	50%
2920	Recement Crown	50%
2950	Core Buildup, Including Any Pins	50%
2951	Pin Retention per Tooth, in Addition to Restoration	50%
2952	Cast Post & Core in Addition to Crown	50%
2953	Cast Post as Part of Crown Same Tooth	50%
2954	Pre-fab Post & Core in Addition to Crown	50%
2960	Labial Veneers (Resin Laminate) Chairside	60%
2961	Labial Veneers (Resin Laminate) Laboratory	60%
2962	Labial Veneers (Porcelain Laminate) Laboratory	60%
2980	Crown Repair - By Report	50%
Endodontics (Root Canal Therapy) - General Dentist Office		
****	Endo Consultation	No Charge
3110	Pulp Cap Direct	50%
3120	Pulp Cap Indirect	50%
3220	Vital Pulpotomy	50%
3310	Root Canal-Anterior	50%
3320	Root Canal-Bicuspid	50%
3330	Root Canal-Molar	50%
3340	Root Canal-Four Canals	50%
3410-26	Apicoectomy	50%
9974	Internal Bleaching after Endodontic Treatment	60%
Periodontics - General Dentist Office		
****	Perio Consultation	No Charge
0180	Comprehensive Perio Examination	60%
4210	Gingivectomy or Gingivoplasty (per quadrant)	60%
4211	Gingivectomy or Gingivoplasty (1 to 3 teeth per quadrant)	60%
4220	Gingival Curettage (per quadrant)	60%
4240	Gingival Flap Surgery (per quadrant)	60%
4241	Gingival Flap Surgery (1 to 3 teeth per quadrant)	60%
4260	Osseous Surgery (per quadrant)	60%
4261	Osseous Surgery (1 to 3 teeth per quadrant)	60%
4263	Bone Replacement Graft-First Site in Quadrant	60%
4264	Bone Replacement Graft-Each Additional Site	60%
4270	Pedicle Soft Tissue Graft Procedure	60%
4271	Free Soft Tissue Graft (Including Donor Site)	60%
4341	Periodontal scaling & root planing (per quadrant)	60%
4342	Periodontal scaling & root planing(1 to 3 teeth per quadrant)	60%
4355	Full mouth debridement	60%
Prosthodontics (Removable) - General Dentist Office		
5110	Complete Dentures-Upper	50%
5120	Complete Dentures-Lower	50%
5130	Immediate Upper Denture	50%
5140	Immediate Lower Denture	50%
5211	Partial Denture-Upper/Resin Base	50%
5212	Partial Denture-Lower/Resin Base	50%
5213	Partial Denture-Upper/Cast Metal Framework/Resin Base	50%
5214	Partial Denture-Lower/Cast Metal Framework/Resin Base	50%
5730-31	Reline Upper/Lower Complete Denture Chairside	50%
5740-41	Reline Upper/Lower Partial Denture Chairside	50%
5750-51	Reline Upper/Lower Complete Denture (Lab)	50%
5760-61	Reline Upper/Lower Partial Denture (Lab)	50%
5810	Interim Complete Denture-Upper	50%
5811	Interim Complete Denture-Lower	50%
5820	Interim Partial Denture-Upper	50%

5821	Interim Partial Denture-Lower	50%
****	All other denture and partial related procedures	50%
****	Laboratory Fees are Not Covered by the Dental Source Plan	

Prosthodontics - General Dentist Office

6240	Pontic-Porcelain Fused to High Noble Metal	50%
6241	Pontic-Porcelain Fused to Predominantly Base Metal	50%
6242	Pontic-Porcelain Fused to Noble Metal	50%
6750	Crown-Porcelain Fused to High Noble Metal	50%
6751	Crown-Porcelain Fused to Predominantly Base Metal	50%
6752	Crown-Porcelain Fused to Noble Metal	50%
6790	Crown-Full Cast High Noble Metal	50%
6791	Crown-Full Cast Predominantly Base Metal	50%
6792	Crown-Full Cast Noble Metal	50%
6930	Recement Bridge	50%
****	Laboratory Fees are Not Covered by the Dental Source Plan.	

Oral Surgery - General Dentist Office

****	Oral Surgery Consultation	No Charge
7111	Extraction-Coronal Remnants-Primary	50%
7140	Extraction-Erupted Tooth or Exposed Root	50%
7210	Surgical Removal of Erupted Tooth	75%
7220	Removal of Impacted Tooth-Soft Tissue	75%
7230	Removal of Impacted Tooth-Partial Bony	75%
7240	Removal of Impacted Tooth-Complete Bony	75%
7310-11	Alveopolasty in Conjunction with Extractions/Per Quadrant	50%
7320-21	Alveoloplasty Not in Conjunction with Extractions Per Quadrant	50%
7470	Removal of Exostosis	50%
7510	Incision & Drainage of Abscess-Intraoral	50%
7520	Incision & Drainage of Abscess-Extraoral	50%
7960	Frenectomy	50%
****	Post Operative Treatment (including dry socket treatment)	No Charge

Orthodontics (Braces) - General Dentist Office

****	Ortho Consultation (at General Dentist Only)	No Charge
****	Ortho Treatment Plan (Records & Models)	75%
****	Orthodontic Appliance	75%
****	Orthodontic Appliance Therapy	75%
****	Orthodontic Treatment	75%

Adjunctive General Services - General Dentist Office

9110	Palliative Treatment (Normal Office Hours)	$15.00
9215	Local Anesthesia	No Charge
9430	Office Visits For Observation (Normal Office Hours)	No Charge
9440	Emergency office visit (After Office Hours)	$25.00
9450	Treatment Plan Presentation	No Charge
9940	Occlusal Guards-By Report	60%
9951	Occlusal Adjustment- Limited	60%
9952	Occlusal Adjustment- Complete	60%
9999	Broken Appointments are subject to a $10.00 charge for each 15 minutes of scheduled time	

EMERGENCY TREATMENT COVERAGE:

In the event of a dental emergency, Dental Source members should contact their selected Dental Source provider. If the Dental Source provider is unavailable for emergency care within 24 hours, members may obtain emergency services from any licensed dentist. The covered emergency services include palliative treatment to control pain, bleeding, or infection. Dental Source members can be reimbursed up to $50.00-based on the Dental Source Schedule of benefits. The member's selected Dental Source provider must provide any further restorative service. In order to receive reimbursement for fees paid, less any applicable copayment, the member must notify Dental Source within two working days of the onset of the emergency, and written request for reimbursement with receipts must be received by Dental Source within 30 days of the onset of the emergency.

EXCLUSIONS AND LIMITATIONS - GENERAL DENTIST

1. Laboratory fees or lab related charges.
2. Prophylaxis (cleanings) and fluoride treatments are limited to one every 6 months. Difficult prophylaxis (i.e. heavy smoker, very neglected teeth) is subject to a $20.00 charge.
3. Procedures provided by any dentists including specialists who are not within the Dental Source provider network.
4. Procedures provided by a participating Dental Source dentist other than your selected dentist prior to receiving approval from the Dental Source office.
5. Procedures or dental expenses incurred in connection with any dental procedure started prior to the member's eligibility or in progress at the time of application. Dental expenses incurred if a participating dentist is unable to perform a procedure due to a member's general health or physical condition (i.e. patient physically unable to visit dentist office or suffering from a contagious illness or disease).
6. Dental expenses incurred after termination of eligibility.
7. Charges for broken appointments.
8. Any dental procedure not listed as a covered service including but not limited to general anesthesia, the services of an anesthesiologist, prescription medication, nitrous oxide, implants, treatment required by reason of war, hospital and medical charges of any kind, surgery of fractures and dislocations, loss or theft of dentures or bridgework, and the treatment of malignancies.
9. Services that are provided to the member by state government, or agencies thereof, or services provided without cost to the member by any municipality, county, or other subdivision.
10. Procedures, appliances, or restorations to correct congenital, developmental, or medically induced dental disorders, including but not limited to, treatment of myo-functional, myo-skeletal, or temporomandibular joint dysfunction (TMJ).
11. Dentures, bridges, and other appliances installed under this program can be replaced only once during the period of 5 years after the original installation. A denture, crown, bridge, or other appliance can be replaced only if it cannot be made satisfactory by reline or repair.
12. A denture, bridge, or other appliance installed while not covered by Dental Source will be replaced only if it cannot be made satisfactory by reline or repair.
13. All covered replacements are subject to the copayment percentages as listed in the Schedule of Services.
14. Crowns are covered only if the dentist determines that there is not enough retentive quality left in a tooth to hold a filling.
15. Replacement of a satisfactory filling is not covered.
16. Fluoride treatments are limited to once every 6 months to age 19.
17. Any dental procedure solely for the purpose of cosmetic reasons is not a covered benefit.
18. Sealants covered through age 15, replaced at no charge within 12 months of original application.
19. A dependent child shall be covered until the age of 25; if unmarried, a state resident and not covered under another benefit plan or government program.

THIS FEE SCHEDULE IS ONLY APPLICABLE FOR THOSE SERVICES PROVIDED BY A PARTICIPATING DENTAL SOURCE GENERAL DENTIST. IF THE SERVICES OF A PARTICIPATING SPECIALIST ARE REQUIRED, MEMBERS WILL RECEIVE A DISCOUNT FROM THAT PARTICIPATING SPECIALIST.

PROCEDURES NOT LISTED ARE NOT COVERED BY DENTAL SOURCE.

Dental Source

Schedule of Benefits/Co-Pays

City of St. Louis

Free Access Plan I

ADA CODE	PROCEDURE	
Diagnostic and Preventive		
0120	Periodic Oral Examination	No Charge
0140	Emergency Oral Evaluation-Problem Focused	20.00
0150	Comprehensive Oral Evaluation	No Charge
0210	Full Mouth X-Ray (Once Every 5 Years)	15.00
0220	Initial Periapical X-Ray	No Charge
0230	Additional Periapical X-Ray	No Charge
0240	Occlusal X-Ray	No Charge
0270	Bitewing - One Film (Two A Year)	No Charge
0272	Bitewings - Two Films (Once A Year)	No Charge
0273	Bitewings - Three Films (Once A Year)	No Charge
0274	Bitewings - Four Films (Once A Year)	No Charge
0330	Panoramic X-Ray (Once Every 5 Years)	15.00
0460	Tooth Pulp Vitality Test	No Charge
1110	Prophylaxis-Adult (Once Every 6 Months)	No Charge
1120	Prophylaxis-Child (Once Every 6 Months)	No Charge
1203	Application of Fluoride (To Age 19) Two Per Year	No Charge
1351	Sealant	12.00
1510	Space Maintainer-Fixed-Unilateral	65.00
1515	Space Maintainer-Fixed-Bilateral	65.00
1520	Space Maintainer-Removable-Unilateral	80.00
1525	Space Maintainer-Removable-Bilateral	80.00
Restorative (Fillings, Inlays and Onlays)		
2140	Amalgam-Primary 1 Surface	10.00
2150	Amalgam-Primary 2 Surfaces	16.00
2160	Amalgam-Primary 3 Surfaces	21.00
2161	Amalgam-Primary 4+ Surfaces	25.00
2140	Amalgam-Permanent 1 Surface	11.00
2150	Amalgam-Permanent 2 Surfaces	18.00
2160	Amalgam-Permanent 3 Surfaces	23.00
2161	Amalgam-Permanent 4+ Surfaces	28.00
2330	Resin-Based Composite-1 Surface-Anterior	20.00
2331	Resin-Based Composite-2 Surfaces-Anterior	30.00
2332	Resin-Based Composite-3 Surfaces-Anterior	40.00
2335	Resin-Based Composite 4+ Surfaces-Ant. (Incisal Angle)	60.00
2390	Resin-Based Composite Crown -Anterior	80.00
2391	Resin-Based Composite Permanent-Posterior 1 Surface	50.00
2392	Resin-Based Composite Permanent-Posterior 2 Surfaces	55.00
2393	Resin-Based Composite Permanent-Posterior 3 Surfaces	60.00
2510 *	Inlay-Metallic-1 Surface	185.00
2520 *	Inlay-Metallic-2 Surfaces	210.00
2530 *	Inlay-Metallic-3 Surfaces	235.00
2543 *	Onlay-Metallic-3 Surfaces	250.00
2544 *	Onlay-Metallic-4 or More Surfaces	265.00
2610	Inlay-Porcelain/Ceramic 1 Surface	215.00
2620	Inlay-Porcelain/Ceramic 2 Surfaces	250.00
2630	Inlay-Porcelain/Ceramic 3 or More Surfaces	260.00
Restorative (Crowns-Single Restorations)		
2720 *	Crown-Resin with High Noble Metal	275.00
2721***	Crown-Resin with Predominantly Base Metal	235.00
2740	Crown-Porcelain/Ceramic	235.00
2750 *	Crown-Porcelain Fused to High Noble Metal	235.00
2751 ***	Crown-Porcelain Fused to Predominantly Base Metal	235.00
2752 **	Crown-Porcelain Fused to Noble Metal	275.00
2781 ***	Crown-3/4 Cast Metallic	275.00
2790 *	Crown-Full Cast High Noble Metal	295.00
2791 ***	Crown-Full Cast Predominantly Base Metal	265.00
2792 **	Crown-Full Cast Noble Metal	275.00
2910	Re-cement Inlay	20.00
2920	Re-cement Crown	20.00
2930	Stainless Steel Crown – Primary	68.00
2931	Stainless Steel Crown – Permanent	75.00
2940	Sedative Fillings	12.00
2950	Crown Buildup, Including Any Pins	60.00
2951	Pin Retention per Tooth, in Addition to Restorations	18.00
2952	Cast Post & Core in Addition to Crown	100.00
2954	Pre-Fab Post & Core in Addition to Crown	80.00
2960	Labial Veneers (Laminate) Chairside	225.00
2961	Labial Veneers (Resin) Lab	275.00
2962	Labial Veneers (Porcelain) Lab	300.00
2970	Temporary Crown (Fractured Tooth)	75.00
2980	Crown Repair-By Report	30.00
	**95.00 Per Unit ** 85.00 Per Unit ***75.00 Per Unit*	
Endodontics		
3110	Pulp Cap Direct	15.00
3120	Pulp Cap Indirect	12.00
3220	Therapeutic Pulpotomy	48.00
3310	Root Canal-Anterior	125.00
3320	Root Canal-Bicuspid	180.00
3330	Root Canal-Molar	250.00
3346	Rereatment of Root Canal-Anterior	200.00
3347	Retreatment of Root Canal-Bicuspid	285.00
3348	Retreatment of Root Canal-Molar	300.00
3410	Apicoectomy-Anterior	140.00
3421	Apicoectomy- Bicuspid, First Root	140.00
3425	Apicoectomy- Molar, First Root	175.00
3426	Apicoectomy- Each Additional Root	80.00
3430	Retrograde Filling- Per Root	50.00
3450	Root Amputation- Per Root	75.00
9974	Internal Bleaching After Endodontic Treatment	55.00
Periodontics		
4210	Gingivectomy or Gingivoplasty (Per Quadrant)	115.00
4211	Gingivectomy or Gingivoplasty(1 to 3 Teeth Per Quad.)	35.00
4240	Gingival Flap Surgery (Per Quadrant)	265.00
4249	Clinical Crown Lengthening-Hard Tissue	300.00
4260	Osseous Surgery (Per Quadrant)	300.00
4263	Bone Replacement Graft-First Site	200.00
4264	Bone Replacement Graft-Each Additional Site	180.00
4270	Pedicle Soft Tissue Graft Procedure	225.00
4271	Free Soft Tissue Graft	225.00
4341	Periodontal Scaling & Root Planing (Per Quadrant)	115.00
4342	Periodontal Scaling & Root Planing (1-3 Teeth)	95.00
4910	Periodontal Maintance Prophylaxis	35.00
Prosthodontics (Removable)		
5110	Complete Dentures-Upper	300.00
5120	Complete Dentures-Lower	300.00
5130	Immediate Denture- Upper	330.00
5140	Immediate Denture- Lower	330.00
5211	Partial Denture-Upper/Resin Base	295.00
5212	Partial Denture-Lower/Resin Base	295.00
5213	Partial Denture-Upper/ Metal Framework/Resin Base	325.00
5214	Partial Denture-Lower/ Metal Framework/Resin Base	325.00
5410	Adjust Complete Denture-Upper	15.00
5411	Adjust Complete Denture-Lower	15.00
5421	Adjust Partial Denture-Upper	15.00
5422	Adjust Partial Denture-Lower	15.00
5510	Repair Denture Base	35.00
5520	Replace Broken Tooth	35.00
5610	Repair Resin Saddle or Base	40.00
5620	Repair Cast Framework	35.00
5630	Repair or Replace Broken Clasp	35.00
5640	Replace Broken Tooth-Per Tooth	35.00
5650	Add Tooth to Existing Partial	35.00
5660	Add Clasp to Existing Partial	40.00
5730	Reline Upper Denture (Chairside)	75.00
5731	Reline Lower Denture (Chairside)	75.00

5740	Reline Upper Partial (Chairside)	70.00
5741	Reline Lower Partial (Chairside)	70.00
5750	Reline Upper Denture (Lab)	100.00
5751	Reline Lower Denture (Lab)	100.00
5760	Reline Upper Partial (Lab)	95.00
5761	Reline Lower Partial (Lab)	95.00
5850	Tissue Conditioning (Maxillary)	50.00
5851	Tissue Conditioning (Mandibular)	50.00
5862	Precision Attachment By Report	160.00

Prosthodontics

6210 *	Pontic-Full Cast High Noble Metal	295.00
6211 ***	Pontic-Full Cast Base Metal	235.00
6212 **	Pontic-Full Cast Nobel Metal	275.00
6240 *	Pontic-Porcelain Fused to High Noble Metal	295.00
6241 ***	Pontic-Porcelain Fused to Predominantly Base Metal	275.00
6242 **	Pontic-Porcelain Fused to Noble Metal	275.00
6251 *	Pontic-Resin with High Noble Metal	275.00
6252 ***	Pontic-Resin with Base Metal	235.00
6545	Retainer Cast Metal for Acid Etch Fixed Prosthesis	125.00
6720 *	Crown-Resin with High Noble Metal	275.00
6721 ***	Crown-Resin with Base Metal	235.00
6750 *	Crown-Porcelain Fused to High Noble Metal	275.00
6751 ***	Crown-Porcelain Fused to Predominantly Base Metal	275.00
6752 **	Crown-Porcelain Fused to Noble Metal	275.00
6780 ***	Crown-3/4 Cast	275.00
6790 *	Crown-Full Cast High Noble Metal	295.00
6791 ***	Crown-Full Cast Predominantly Base Metal	265.00
6792 **	Crown-Full Cast Noble Metal	275.00
6930	Recement Bridge	58.00
6940	Stress Breaker	110.00
6950	Precision Attachment	180.00
6980	Bridge Repair By Report	55.00

**95.00 Per Unit ** 85.00 Per Unit ***75.00 Per Unit*

Oral Surgery

7111	Extraction-Coronal Remnants-Primary	25.00
7140	Extraction-Erupted Tooth or Exposed Root	25.00
7210	Surgical Removal of Erupted Tooth	50.00
7220	Removal of Impacted Tooth-Soft Tissue	70.00
7230	Removal of Impacted Tooth-Partial Bony	90.00
7240	Removal of Impacted Tooth-Complete Bony	110.00
7241	Removal of Impacted Tooth-Full Bony W/Comp	150.00
7250	Removal of Residual Roots	35.00
7280	Surgical Access of Unerupted Tooth (Excludes Ortho)	40.00
7310	Alveopolasty in Conjunction with Extractions/Per Quad	100.00
7311	Alveopolasty in Conjunction with Extractions/1-3 Teeth	85.00
7320	Alveoloplasty Not In Conjunction With Extractions/Per Quad	150.00
7321	Alveoloplasty Not In Conjunction With Extractions/1-3 Teeth	135.00
7471	Removal of Lateral Exostosis	225.00
7510	Incision & Drainage of Abscess-Intraoral	55.00
7960	Frenectomy	80.00

Adjunctive General Services

9230	Analgesia-Nitrous Oxide (Per 30 Minutes)	25.00
9310	Consultation By Specialist	30.00
9440	Emergency office visit (Non-office hours)	40.00
9910	Application of Desensitizing Medicament	20.00
9940	Occlusal Guard	75.00
9941	Fabrication of Athletic Mouthguard	80.00
9951	Occlusal Adjustment Limited	55.00
9952	Occlusal Adjustment Complete	125.00

EMERGENCY TREATMENT COVERAGE:

In the event of a dental emergency, Dental Source members should first contact a participating Dental Source Provider. The Provider should be able to treat you as soon as possible to relieve pain until a full appointment can be scheduled. If the Provider is unavailable for an emergency visit, you may contact any other location within the network or contact Dental Source for assistance.

ORTHODONTIC BENEFITS

The member will receive a discount up to 25% from the Dental Source Network Orthodontists.

OUT OF AREA EMERGENCY COVERAGE:

If an emergency arises when member or eligible dependent is temporarily more than 50 miles from nearest network Dentist, the covered services are for palliative treatment to control pain, bleeding, or infection. Dental Source members will be reimbursed up to $50.00 based on the Dental Source Schedule of Benefits. Any further restorative service must be provided by participating Dental Source Provider. In order to receive reimbursement for fees paid, less any applicable co-payment, the member must notify Dental Source within two working days of the onset of the emergency, and written request for reimbursement with receipts must be received by Dental Source within 30 days of the onset of the emergency.

EXCLUSIONS AND LIMITATIONS - GENERAL DENTIST

1. Prophylaxis, including periodontal maintance, and fluoride treatments are limited to one every 6 months. Difficult prophylaxis (i.e. heavy smoker, neglected teeth) is subject to a $25.00 charge.
2. Frequency of exams is limited to two a year.
3. Cost of precious, semi-precious and base metal are Patient's responsibility.
4. Procedures provided by any dentists including specialists who are not within the Dental Source Provider network.
5. Dental treatment commenced prior to the member's eligibility or in progress at the time of application or expenses incurred after termination from plan are not covered.
6. Dental expenses incurred if a participating dentist is unable to perform a procedure due to a member's general health or physical condition (i.e. patient physically unable to visit dentist office or suffering from a contagious illness or disease).
7. Charges for broken appointments.
8. Any dental procedure not listed as a covered service including but not limited to general anesthesia, the services of an anesthesiologist, prescription medication, implants, treatment required by reason of war, hospital and medical charges of any kind, surgery of fractures and dislocations, loss or theft of dentures or bridgework, and the treatment of malignancies.
9. Services provided to the member by state government, or agencies thereof, or services provided without cost to the member by any municipality, county, or other subdivision.
10. Procedures, appliances, or restorations to correct congenital, developmental, or medically induced dental disorders, including but not limited to, treatment of myo-functional, myo-skeletal, or temporomandibular joint dysfunction (TMJ).
11. Dentures, bridges, and other appliances fabricated under this program can be replaced only once during the period of 5 years after the original insertion. A denture, bridge, or other appliance can be replaced only if it cannot be made satisfactory by reline or repair.
12. A denture, bridge, or other appliance installed while not covered by Dental Source will be replaced only if it cannot be made satisfactory by reline or repair.
13. All covered replacements are subject to the co-payment as listed in the Schedule of Benefits. Replacement of dentures, appliances or bridgework due loss or theft is not covered.
14. Crowns are covered only if the dentist determines that there is not enough retentive quality left in a tooth to hold a filling.
15. Replacement of a satisfactory filling is not covered.
16. Any dental procedure solely for the purpose of cosmetic reasons is not a covered benefit.
17. Sealants are covered through the age 14; replacements covered at no charge within the first twelve months of original application.
18. Fluoride treatments are limited to once every 6 months to age 19.
19. Failure to pay a scheduled co-payment may prevent future dental services from being received until all fees have been paid in full.
20. A dependent child shall be covered until the age of 25; if unmarried, a state resident and not covered under another benefit plan or government program.